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ABSTRACT

Although death and the circumstances surrounding it are inevitable for all people, open discussions of this subject are considered morbid and thus taboo. The fear of death, however, greatly affects the care administered to dying patients in a health care setting by professionals, family, and friends. A mail survey was administered to 247 individuals, aged 24 to 72, identified from five occupational groups in San Diego County: physicians, nurses, clergy, social workers, and psychologists. The fear of death, a dependent variable, was measured by Feifel's Metaphor Scale and a death adjective semantic differential scale. Data analysis revealed that statistical relationships existed between fear of death and occupation, religious affiliation, and religiosity. Multiple regression, however, did not yield many significant correlations. Age, sex, educational level, and death education training had no significant effect on the attitudes toward death among health care providers. Because imprecise measurement of indicators presents a problem in this type of research, more reliable scales are needed. (Data tables are included.) (Author/TW)

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CONTRASTS AND SIMILARITIES IN ATTITUDES TOWARD DEATH OF HEALTH CARE PROVIDERS

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Paper presented at the Annual Meeting of the Gerontological Society of America, New Orleans, Louisiana

CONTRASTS AND SIMILARITIES OF HEALTH CARE PROVIDERS ATTITUDES TOWARD DEATH

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The degree of concern health care providers have about death becomes an important issue in the context of their work with dying patients. This study employed mail survey data. The survey involved 247 individuals, age 24 to 72, identified from five occupational groups in San Diego County: physicians, nurses, clergy, social workers, and psychologists. The two integral measures of the dependent variable -- fear of death -- were Feifel's Metaphor Scale and a death adjective semantic differential scale. Analysis focused on the extent to which death attitudes were predictable by health care provider group and from demographic characteristics. There were no statistically significant differences in death attitudes among health care providers based on their age, sex, educational level, or death education training. Of the predictor variables used, religious affiliation, religious self rating, and occupation were the three variables that are significantly related to fear of death. Overall, with reference to differences to ranking of health care providers, it is concluded that these data cannot pinpoint a specific reason for different levels of death anxiety. Religion appears to play a sustaining role. However, other possible explanations such as self-selected occupational recruitment or socialization processes are not documented.

INTRODUCTION

Death is a life event that all individuals will experience. Even before its actual arrival, death is for most, as Feifel (1977) has noted, an "absent presence." In fact, it is a safe generalization to say that nearly all, if not everyone, fears death or dying at some time[1].

Twentieth century people are uncomfortable confronting death (Aries, 1974; Kabler-Ross, 1975; Moss, McGaghie, and Rubenstein, 1976). Death is seen as a threat for personal and social reasons, a reminder of the finiteness of human experience. This avoidance of death has caused its displacement from everyday reality. Death is seen as taboo and its discussion regarding as morbid. As such, death is the subject of much pretense, denial and fear.

One would think that since death is a universal experience we would find solace in discussing the issue instead of holding it a taboo subject. This would seem especially so for two particular groups in our society. For patients with terminal illness, and the health care personnel responsible for their care, death is an ever-present reality (DiMatteo and Friedman, 1982; Kastenbaum, 1977).[2]

When Sigmund Freud was struggling with his own attitudes toward death he wrote:

> Would it not be better to give death the place in actuality and in our thoughts which properly belongs to it, and to yield a little more prominence to that attitude toward death which we hither to so carefully repressed. . . .We remember the old saying: Si vis pacem, para bellum. If you desire peace, prepare for war. It would be timely this to paraphrase it: Si vis vitam, para mortem. If you endure life be prepared for death.[3]

Freud's notions regarding preparation for death are not unique. Throughout man's history the idea of death has posed the mystery par excellence which is the core of some of our most important religious and philosophical systems of thought. Anthropologists have pointed out that humanity has been fascinated, preoccupied, and obsessed with death since the beginnings of life (Huntington and Metcalf, 1976; Lessa and Vogt, 1958).

This assertion find further support from the arts. The subject of death has long been used in artistic expression. Gottlieb (1959:157) suggests that

> art generally seeks its inspiration from the important in human life. Along with birth and marriage, death marks a definite peak in an individual's existence. Small wonder, then, that the theme of death is a common subject in art, found in all styles and dating back to the creations of the cave man.

Writers, painters, poets, and composers symbolized their feelings about death and dying in an endless variety of beauty, acceptance, opposition, anger and fear.

Kavanaugh (1974) directs blame toward professional vocabularies in saying that Americans have no real household expressions that can be easily and readily understood by all concerned in communicating aspects of human mortality. Medical and religious vocabularies, for example, suggest that health care providers also have been captured by society's orientation to life and death — one that emphasizes the future and views death as an "abomination" (Weisman, 1972).

All one need do is review the literature on care of the dying and it becomes evident that the topic has become a significant issue in the health care system.[4] Part of the problem stems from the fact that mortality patterns have been radically altered; more people are living longer and are dying from degenerative processes and chronic conditions which require extended care. Avoidance behavior by health care providers, when faced with dying patients who require long term care, is a second source of the problem. Problems dealing with death bring to the surface a growing concern about treating the dying as living human beings, in need of care, compassion, friendship and loyalty. These become important considerations when we realize that a major part of the social context within which dying occurs is determined by attitudes, feelings and behavior of the health care personnel attending the patient, whose usual concern is returning patients to a healthy status.

Becoming a "patient" affect the physical, social, and psychological well being of a person. When dying persons enter a health care facility they relinquish considerable control over the course of dying. How individuals learn to cope with the significant losses associated with death and dying is affected by the kins and quality of resources health care staff make available to them. In other words, as dying patients search for new coping strategies and ways of explaining the changes around and within them, the quality of health care becomes a major concern. Quality health care meaning we should remember that since dying is a unique experience in each life, the person who is dying should rightly expect some special consideration and indulgence. Health care providers, many of whom see dozens of people die, need to remember that what is familiar for the, is the individual patient's biggest adventure.

Statement of the Problem

The degree of concern that health care providers have about death becomes an important issue in the context of their work with patients who are dying. In order to understand more fully the complexity of interaction between health care providers and dying patients, it is important to obtain information about who the health care providers are, and the attitudes they have toward death.

Patient care as an ideal rests on a historical foundation. This ideal has special importance in regard to death and dying. All societies have constructed social arrangements for limiting the impact of death as an aspect of experience. Yet despite this universal, only in the past two decades has the study of death as a social process caught the attention of medical sociologists (Becker, 1973; Cockerham, 1982).

Blauner's (1966) early work and Kalish's (1985) recent echoes also remind us of the importance of how society handles death. Blauner (1966:379) has so aptly pointed out that "death disrupts the dynamic equilibrium of social

life." This is so because its actual or potential consequences create problems for a society. Perhaps the most obvious of these potential consequences is a social vacuum. When a member of society and his or her constituent groups and relationships are lost, some kind of gap in institutional functioning results (Blauner, 1966; Kalish, 1985). Thus, the way society and its medical institution manages the death crisis becomes an important consideration.

More concretely, we must look at medical encounters in regard to death as also being noteworthy because they are composed of a large number of concerns judged to fall outside the range of strict biomedical definition. Not much is known about the fate of such concerns, interactionally or in terms of behavior in subsequent social and linguistic contexts. Thus, the medical encounter with death potentially represents a type of health care transaction in which problems are most readily dealt with in social rather than biological terms (Charmaz, 1980; Frankel, 1984a, Mappes and Zembaty, 1981; Mishler, 1984).

Until recently, most of the research concerning death and dying has portrayed the dying process as a lonesome and perhaps even an inhumane experience in modern hospitals. Attempts by health care staff and the dying patient's family to interact with the patient have been seen as being inhibited in a socially meaningful way (Boyle, 1970; Charmaz, 1980; Cockerham, 1982; DiMatteo and Friedman, 1981, 1979; Gardner and Skipper, 1984; Korsch and Negrete, 1972; Lamerton, 1976; Ley and Spelman, 1967; McKinley, 1975; Milner, 1980; Rea, et. al,1975; Samora, et. al,1961; Silver, 1979; Stoller, 1980; Sudnow, 1967; Waitzkin and Stoeckle, 1976, 1972). Early attempts to isolate so-called "barriers" to communication between health care providers and patients, such as the well-known paper by Samora et al. (1961), tended to ascribe culpability to patients. Currently, however, the patient is perceived to be socially and psychologically isolated. The role assigned to dying patients is characteristic of qualities associated with "victimization." Furthermore, health care providers are presented via a "villain" role, for not displaying humanistic attitudes and/or behaviors (Gardner and Skipper, 1984; McKinlay and Arches, 1985).

Society has assigned certain professionals the task of dealing with death. Encounters with death and dying tend to be the common dimension of the world of health care providers. Because people choose to die in hospitals, or perhaps their families make such choices for them, means that outsiders (health care providers) to the family are delegated the responsibility for taking care of the dying during their final hours, to fulfill an essential function formerly managed by the family (Aries, 1974; Mumford, 1983; Uhlenberg, 1980). This delegation of responsibility, whether partial or total, is significant for everyone concerned: for patients, families, and of course, for health caregivers (Glaser and Strauss, 1965; Strauss, et. al, 1985).

Worth noting is that to talk with, work with, and try to understand dying persons can evoke potentially intense personal feelings. The care of the dying arouses some of the most pervasive fears of all people--extinction, helplessness, abandonment, and loss of self-esteem. Because of this fact, it should be rather obvious that we could not long survive, much less serve our fellow beings, if we had to contemplate and struggle continuously at the raw edge of our existence (Weisman, 1972).

By no means should one imply that health care providers are not willing to provide compassionate support. On the contrary, recent research has shown that for some health care providers grief is a commonplace reaction to suffering, loss and death of patients (DiMatteo and Friedman, 1982; Lessa and Limauro, 1981). In addition, Shanfield (1981:385) refers to health care providers as "survivors of complex and manifold losses." The loss of health care provider's idealized role expectations and patients' deaths are among reasons cited as occasions for grief among health care teams.

Furthermore, when considering health care provider and patient interactions, one must also expect that some patients do not come to terms with their fate, and demand reassurance to the end (Kotarba, 1983; Kubler-Ross, 1969). Any proponents of informed consent and patient self- determination have to consider this fact and also realize the potential problems and complexities of patients becoming aware of the "certainties" and "uncertainties" that surround the practice of medicine. To integrate them with the patients' hopes, fears, and realistic expectations, are inordinately difficult tasks (Katz, 1984). Since health care providers do indeed have superior knowledge and expertise for treatment tasks, the patient can never be a true equal in this area (Fisher, 1984; Freidson 1967; Lorber, 1976; Yedidia, 1980).

METHODOLOGY

Research Design

This study is exploratory, and thus, descriptive. Exploratory studies are typically conducted for three purposes: (1) to satisfy the researcher's curiosity for better understanding; (2) to test the feasibility of undertaking a more careful study; and (3) to develop methods to be employed in a more careful study (Babbie, 1979). The design and goals of this research are consistent with these purposes.

This study is also analytical. In addition to a descriptive analysis, the various data collected will also permit statistical analyses and correlational conclusions. However, due to the limited research available, the central concentration of this study is descriptive. Taking this into consideration, this research is based on the premise that praxis is a basis for theory.

Definition of Variables

The principal dependent variable in this study is attitude toward death, anxiety, concern for death, or more simply put, the fear of death. The concept of "attitude toward death" has been operationalized by different authors as "Death Concern" (Dicksten, 1972); "Fear of Death" (Collett and Lester, 1969; Feifel, 1959; Feifel and Schag, 1980; Lester, 1967; Sarnoff and Corwin,, 1959); and "Death Anxiety" (Templer, 1970). Death concern, fear of death, and death anxiety are terms that will be used interchangeably here.

The reader may be aware of this distinction often made by psychoanalysts between fear and anxiety. However, integral measures of the dependent variable, such as a death adjective semantic differential scale and a multilevel measure such as Feifel's metaphor scale tend to tap both of these

aspects, that is, fear of a specific event or object available to conscious awareness and more covert anxiety concerns (Feifel and Schag, 1980).

The principal independent variables include: occupation/vocation (physicians, nurses, clinical psychologists, medical social workers, and clergy); and sociodemographic characteristics such as age, gender, religion, and education. Other variables include death attitude measures such as belief in an afterlife; self-perceived death attitude influences, such as influence of religious upbringing, influence of rituals, influence of introspection, and influence of death of someone close; and religious rating of self.

Population and Setting

The study site is San Diego County, California, with a total population of 1.97 million in 1982. The city of San Diego, which comprises approximately half of the total county population (898,500) is the second largest city in California and the seventh largest metropolitan statistical area in the nation (San Diego Association of Government, 1982; San Diego Chamber of Commerce, Economic Research Bureau, 1982).

Sample Size and Procedures

The respondents for this survey were selected from various pertinent local health service agencies, professional societies and schools with which they were affiliated. A sampling frame was created gathering membership directories and mailing lists from the following agencies: the San Diego Hospice Corporation; the San Diego County Ecumenical Conference; California Nurses' Association, Region 1; National Association of Social Workers, Inc., California Chapter; Forum for Death Education and Counseling, san Diego Chapter; Academy of San Diego Psychologists; the San Diego County Medical Society; and the School of Nursing at San Diego State University.

The total population was stratified by occupation (physicians, nurses, clinical psychologists, clinical social workers, and clergy). The potential subjects within each occupational category was totaled. Potential respondents were selected randomly from within each occupational group.

In order to insure independence of the units being sampled, a mechanical means of sampling was used. Utilizing a table of random numbers, every unit was assigned a number; then numbers were drawn from the table of random numbers.

The number of units in the working universe were finite. That is, sampling was conducted without replacement. One hundred potential respondents were selected from each health care group.

Date Collection Methods

The survey data were collected between August 1982, and November 1982, by means of mailed questionnaires. Initially mailed questionnaires, accompanied by a cover letter explaining the nature and purpose of the research project and enlisting the respondents' cooperation, were sent out to potential subjects. When response to the initial mailing had nearly ceased (seven working days), a follow-up reminder letter was sent. After the reminder

letter there was an upsurge. Once again, when the response rate began to wane (approximately seven working days), research subjects were contracted by telephone.

The overall gain in response achieved by the two follow-ups is 18.6 percent. Before the reminder letter the total number of respondents was 154. After the reminder letter, the response rate increased to 204, up 10 percent. The response rate increased an additional 8.6 percent (n = 247) after potential respondents were contacted by telephone.

Instrument Content

Utilized as an integral measure of the dependent variable (fear of death), is Feifel's metaphor scale. The metaphor scale was employed to circumvent more formal, intellectualized conceptions.

Respondents were asked to select from a list of twelve metaphors, that were pre-operationalized as portraying "positive" or "negative" death attitudes, six images or metaphors that best described their perception of personal death. Reliability face and content validity of these twelve metaphors were established in a pilot study (Feifel, 1980; Green and Feifel, 1974). Images were (positive or negative value in parentheses) a blinding fog (-), a comforting mother (+), a devouring tiger (-), a deserved holiday (+), a runaway horse (-), a soft pillow (+), a dreamless space (-), a family picnic (+), a impenetrable wall (-), an open gate (+), an abandoned home (-), and a relieving breeze (+). The values, positive or negative, for the six metaphors selected by each subject were arithmetically combined to form a metaphor summary score with a range from -6 (all negative images chosen) to +6 (all positive images chosen).

The semantic differential technique described by Osgood, Suci and Tannenbaum (1957) was included as a measure of respondents feelings about death. Five bipolar adjectives were selected from the evaluative factor, purported to measure an attitude dimension, and two pairs of adjectives from the potency dimension. All adjectives were rated on the usual seven point scale. The bipolar adjectives were randomly ordered in terms of sequence. Direction was done separately for each concept so that response patterns would not carry from the first scale to the second. The items used were kind-cruel, light-dark, soft-hard, clean-dirty, fair-unfair, gentle-violent, and good-bad. Items were summed to provide a total score.

The final questionnaire consisted of twenty-eight close and open-ended questions, Feifel's Metaphor Scale, and a semantic differential scale.

Data Analysis

Measures of association, ANOVA, and multiple regression were run to analyze the data. The first objective was to find out whether there is a difference on the metaphor or semantic differential scale among occupations. ANOVA was utilized to achieve this objective.

The second objective was to find out the influence of religious variables and several control variables, including occupations, or the mataphor and semantic differential scales. To achieve this objective we ran multiple regression.

RESULTS OF SURVEY DATA

Demographic Characteristics of Respondents

The completed sample size is 247. The distribution by occupation, age, and sex can ben seen in Table 1.

Table 1

Distribution of Respondents by Age and Sex

Occupational group	Sex	N	Percentage at each age		
			24-39	40-45	56+
Physicians	Male	28	39.3	50.0	10.7
	Female	15	53.3	46.7	0.0
Nurses	Male	3	100.0	0.0	0.0
	Female	44	54.5	22.7	22.7
Psychologists	Male	28	35.7	50.0	14.3
	Female	22	40.9	36.4	22.7
Clergy	Male	47	21.3	53.2	25.5
	Female	Ø	0.0	0.0	0.0
Social workers	Male	21	85.7	14.3	0.0
	Female	39	64.1	28.2	7.7

Classification Procedure

For the metaphor scale measure, respondents are categorized into three fear of death groups. Subjects who selected more positive than negative death metaphors are placed in the low fear of death group for this measure (n = 134, 59.0 percent of the sample). Those who selected more negative than positive metaphors are placed in the high fear of death group (n = 53, 23.3 percent of the sample), and those choosing an equal number of positive and negative metaphors (three positive and three negative) are located in the medium death fear group (n = 40, 17.6 percent of the sample).

For the measure of the semantic differential scale the ranges of scores is from 7 to 49. Subjects are grouped into low, medium, and high fear of death categories on this measure. This is done according to whether their scores fell in the lower (7-20, n = 82, 33.3 percent of the sample), middle (21-28, n = 110, 44.7 percent of the sample), or upper third (29-49, n = 54, 22.0 percent of the sample) of the frequency distribution of this measure.

Intercorrelations of Fear of Death Scales

To what extent are these two scales related to each other? Do these two scales reflect a single death dimension, or are they separate attitudinal components with reference to death?

The metaphor and semantic differential scales appear to be measuring a different death dimension. The pearsons correlation coefficient is 0.52. This is significant at the .001 level but still only a moderate positive relationship.

ANOVA test produced significant results also. In fact, utilizing Duncan's A Posteriori Group Contrast Test, the metaphor fear of death group means are significant at .05 when compared with the semantic differential responses.

Respondents with mean scores in the high fear of death group on the metaphor scale also have means that are within the high fear of death grouping on the semantic differential (M = 25.05, SD = 5.18), while subjects classified in the low fear of death group on the metaphor scale also scored within the low fear range on the semantic differential (M = 20.73, SD = 8.36).

Occupation

Results of one-way analysis of variance suggest some systematic variation predictable by occupation. This is so on the metaphor (see Table 2) and semantic differential scales (see Table 3).

Differences in response by occupation are examined using Duncan's multiple range test. The results indicate significant contrasts in terms of occupational group means.

Clergy, nurses, social workers, are most likely to respond positively on the metaphor scale. All these health care providers place within the low fear of death group. Responding significantly different on this measure are psychologists and physicians. Their group means fall within the medium fear

Table 2

ANOVA Table for the Metaphor Score and Occupation

Source of variation	SS	df	MS	F	Significance of F
Occupation	35.305	4	8.826	3.552	0.01
Explained	135.305	4	8.826	3.552	
Residual	549.231	221	2.485		
Total	584.536	225	2.598		

Table 3

ANOVA Table for the Semantic Differential and Occupation

Source of variation	SS	df	MS	F	Significance of F
Occupation	799.127	4	199.782	2.837	0.05
Explained	799.127	4	199.782	2.837	
Residual	15564.832	221	70.429		
Total	16363.959	225			

of death category.

Duncan's multiple range test on the semantic differential occupational group means shows us that clergymen respond differently than other health care professionals. The clergy mean on this measure places them in the low fear of death category. Physicians and nurses are within the lower fourth of the medium fear of death grouping. Psychologists and social workers means are embedded in the middle of the fear of death classification.

Results of the ANOVA and Duncan's multiple range tests indicate significant systematic variation in terms of occupational means. Thus, there seems to be a relationship between fear of death and occupation.

Sex

Results of the one-way analysis of variance suggests there is no significant difference between mean scores according to sex. However, an inspection of means indicates females express greater fear of death than do males. Examination of mean scores on the semantic differential show the females mean at 24.83 while males have a total mean of 21.86. Mean scores on the metaphor measure are virtually identical.

In light of the above, i.e., due to lack of statistical evidence linking sex to fear of death, it appears that sex and fear of death are unrelated. Thus a null hypothesis should be supported by stating these data indicate there is no statistical relationship between sex and fear of death.

Age

There is no significant difference between mean scores of the total sample according to age on the metaphor and semantic differential scales. However, an interesting trend is the tendency of the middle-aged to achieve the overall highest scores. For example, the group mean for the middle-aged on the semantic differential is 24.39 (SD = 7.56). This is compared to the young (M = 22.58, SD = 9.13) and the old (M = 21.54, SD = 9.55). All age groups fall within the medium fear of death group. The middle-aged are in the upper fourth, the young in the middle, and the old in the lower fourth on the frequency distribution of this measure. This is a trend that has been shown elsewhere.

One might have assumed that age and fear of death are related. However, no statistical relationship could be established on either of the fear of death scales. Likewise, there is little systematic variation between mean scores on the metaphor and semantic differential scales according to age.

Religious Affiliation

Review of the one-way analysis of variance for religious affiliation and the metaphor scale shows there appears to be some variance in means in response to this measure by religious groupings (see Table 4). Analysis of variance also indicates some group mean variance in response to the semantic differential (see Table 5).

Table 4

ANOVA Table for the Metaphor Scale and Religious Affiliation

Source of variance	SS	df	MS	F	Significance of F
Religious affiliation	56.560	4	14.140	5.919	0.001
Explained	56.560	4	14.140	5.919	
Residual	527.976	221	2.389		
Total	584.536	225	2.598		

Table 5

ANOVA Table for the Semantic Differential and Religious Affiliation

Source of variance	SS	df	MS	F	Significance of F
Religious affiliation	1294.738	4	323.684	4.747	0.001
Explained	1294.738	4	323.684	4.747	
Residual	15069.222	221	68.187		
Total	16363.959	225	72.729		

Differences in response by religious affiliation are examined utilizing Duncan's A Posteriori Contrast test indicating significant contrasts in terms of religious groupings' means. The Atheist-Agnostic group and the Jewish group respond to items on the metaphor scale significantly differentially at the 0.05 level. Overall, Aetheists and Agnostics, as well as the Jewish grouping, have mean scores placing them in the high fear of death category on this measure. Catholics, Protestants, and Independent faiths all fall within the low fear of death group. Catholics are the least likely to be afraid, followed by Protestants and Independents.

On the semantic differential measure there exists variance in group means and significantly different group response involves the same religious populations. That is, Atheist/Agnostics and Jewish groupings once again respond more negatively and significantly different from other religious affiliations. The Atheist/Agnostic group have a mean that places them in the upper fourth of the medium fear of death classification. Likewise, the Jewish group is strongly embedded on the borderline between the high fear and medium fear of death categories. In fact, the Jewish mean is just 0.28 away form the high fear of death classification ($M = 28.72$, $SD = 5.89$). The Independents fall within the low fear of death group as do the Catholics. The Protestant population is just barely within the medium fear of death group with a mean of 22.49. The significantly different response is at the 5 percent level of confidence.

Additionally, when controlling for religious affiliation in a two-way analysis of variance the main effect is significant at the 1 percent level of confidence ($F = 3.643$) on the semantic differential scale (see Table 6).

Traditional religious tend to claim their "way of life" reduces death fears (Kalish, 1963). At the overt response level religious affiliation appears to be somewhat of a determinant with regard to death fears.

Religious Rating of Self

Religious rating of self, i.e., self-perceived devoutness, also show variance by group means on the metaphor and semantic differential scales. This is indicated by the one-way analysis of variance F-ratio and the significance of F-ratio. For the metaphor scale the F-ratio is 3.12 with a significance of 0.01. The semantic differential measure F-ratio is 4.68 with a significance of 0.001 (see Tables 7 and 8).

Examination of Duncan's multiple range test indicates significant contrasts in terms of a person's self-perceived devoutness and accompanying mean scores on the metaphor scale. Health care providers perceiving themselves as "much more" and "more" religious demonstrate the least fear toward death. Health care providers stating they are "definitely less" religious fall somewhere in the middle with those responding "about the same" or "somewhat less" showing the most fear toward death.

Review of A Posteriori Contrast tests indicate that health care providers who feel they are "much more" or "more" religious than denominational peers respond more positively and significantly different from others on the semantic differential scale. Health care providers who feel they are "much more" or "more" religious compared to others of their religious affiliation place within the low fear of death category on this measure. In fact, those responding "much more" religious have a mean score lower than any other variable grouping on this scale ($M = 16.85$). Health care providers

Table 6

Multiple Classification Analysis

Variable and category	N	Unadjusted		Adjusted for independents	
		Deviation	Eta	Deviation	Beta
Occupation:					
1) Clinical psychologist	44	1.30		0.66	
2) Physician	43	0.06		-0.37	
3) Nurse	45	0.15		0.87	
4) Clinical social worker	56	1.37		1.16	
5) Clergy	41	-3.49		-2.85	
			0.20		0.17
Religious affiliation:					
1) Catholic	52	-1.72		-1.79	
2) Jewish	25	5.16		4.63	
3) Protestant	97	-0.82		-0.28	
4) Independents	24	-2.15		-2.80	
5) Atheist/Agnostics	31	2.95		2.31	
			0.28		0.26
Multiple R squared					0.103
Multiple R					0.320

Note: Grand mean = 23.56.

Table 7

ANOVA Table for the Metaphor Scale and Religiousity

Source of variation	SS	df	MS	F	Significance of F
Religiousity	31.206	4	7.802	3.129	0.05
Explained	31.206	4	7.802	3.129	
Residual	543.556	218	2.493		
Total	574.762	222	2.589		

Table 8

ANOVA Table for the Semantic Differential and Religiousity

Source of variation	SS	df	MS	F	Significance of F
Religiousity	1252.486	4	313.122	4.680	
Explained	1252.486	4	313.122	4.680	
Residual	14586.615	218	66.911		
Total	15839.102	222	71.347		

responding "definitely less" religious are within the middle of the medium fear of death group with health caregivers stating "somewhat less" are in the upper fourth of the medium fear of death group.

Also, when religious rating of self is controlled in a two-way analysis of variance, the main effect is significant on the semantic differential scale ($F = 2.435$, 0.05).

Table 9 reveals that when occupation is adjusted for by religiousity the deviations and beta are lower.

The relationship between fear of death and self-rating of strength of religious beliefs seems to indicate less fear among strong believers. The relative favorable reaction to death shown by those rating themselves high on religiousity should not be too surprising to anyone.

The general conclusions of the above findings may be interpreted to indicate that religiousity and fear of death are statistically related. The stated hypothesis is accepted.

Multiple Regression and Religious Variables

The regression coefficients of religious variables and selected control variables for the metaphor and semantic differential scale did not yield an abundance of significant relationships (see Tables 10 and 11).

Most noteable is the predictor variable belief in an after life. The T-value for belief in an after life on the metaphor and semantic differential scale is significant. Belief in an after life is one dimension of religiousity which recently has received attention in regard to fear of death (Berman and Hays, 1973; Osarchuk and Tatz, 1973; Berman, 1974; Kurlycheck, 1976; Occhsmann, 1984).

In this survey, those stating a belief in an after life score significantly lower on the fear of death scales. Belief in an after life appears to function as a coping mechanism which acts to reduce the fear of death.

It appears that afterlife images, while perhaps varying in intensity, take a singular form across individuals except for one who does not believe in an afterlife. However, there is reason to speculate that, as with other aspects of religious (and nonreligious) beliefs, not only are there varieties of ways of envisioning the afterlife possible, but individual images of the afterlife may contain more than a single dimension.

CONCLUSIONS

Although the magnitude of statistical relationships are not overwhelming, there are some statements that can be made about the data.

It is interesting to note which variables are not perceptively related to fear of death. Namely, there are no statistically significant differences in attitudes toward death among health care providers studied based on their age, sex, educational level, and death education training.

Table 9

Multiple Classification Analysis

Variable and category	N	Unadjusted Deviation	Unadjusted Eta	Adjusted for independents Deviation	Adjusted for independents Beta
Occupation:					
1) Clinical psychologist	50	1.07		0.67	
2) Physician	43	0.34		-0.18	
3) Nurse	47	0.50		0.43	
4) Clinical social worker	59	1.26		0.85	
5) Clergy	43	-3.87		-2.24	
			0.22		0.13
Religiousity:					
1) Much more religious	7	-6.43		-6.25	
2) More religious	60	-3.07		-2.16	
3) About the same	101	0.70		0.48	
4) Somewhat less	40	2.76		2.39	
5) Definitely less religious	34	1.42		0.86	
			0.27		0.22
Multiple R squared					0.088
Multiple R					0.296

Note: Grand mean = 23.29.

Table 10. Regression coefficients of Religious variables and selected control variables for Differential scale

Predictor Variables	Dependent Variable B	Beta	T-value
Belief in afterlife	2.326	0.211	2.901**
Influence of Religious up-bringing	-0.333	-0.027	-0.391
Influence of riturals	0.005	0.005	0.007
Religious Rating of self	0.726	0.087	1.249
Influence of Introspection	1.956	0.107	1.784
Influence of death of someone close	2.530	0.236	3.811**
Age	0.021	0.028	0.433
Education	0.004	0.002	0.016
Religious Affilication			
Catholic	1.115	0.053	0.818
Jewish	-3.067	-0.109	-1.556
Atheist	-1.790	-0.039	-0.613
Agnostic	-0.251	-0.008	-0.119
Independent (Protestants=0)	1.705	0.067	1.037
Sex (Male=0)	-2.724	-0.159	-2.084*
Occupation			
Psychologists	-0.400	-0.019	-0.217
Physicians	1.357	0.060	0.655
Nurse	0.990	0.045	0.558
Clergy (Social workers=0)	0.633	0.029	0.286
Death Education			
No (Yes=0)	1.405	0.082	1.249
(Constant)	26.224		4.579**
R-square	0.249		

Table 11. Regression coefficients of Religious variables and selected control variables for Metaphor scale

Predictor Variables	Dependent Variable B	Beta	T-value
Belief in afterlife	1.242	0.306	4.118**
Influence of Religious up-bringing	0.342	0.076	1.057
Influence of riturals	-0.126	-0.033	-0.491
Religious Rating of self	-0.004	-0.001	-0.018
Influence of Introspection	0.858	0.127	2.071*
Influence of death of someone close	0.452	0.114	1.804
Age	0.000	0.000	0.010
Education	0.131	0.126	1.191
Religious Affilication			
Catholic	0.199	0.026	0.383
Jewish	-0.661	-0.065	-0.892
Atheist	-1.231	-0.075	-1.128
Agnostic	-0.783	-0.071	-0.988
Independent (Protestants=0)	-0.601	-0.063	-0.931
Sex (Male=0)	-0.424	-0.066	-0.862
Occupation			
Psychologists	-1.587	-0.203	-2.250*
Physicians	-1.529	-0.182	-1.868
Nurse	-0.253	-0.032	-0.377
Clergy (Social workers=0)	-0.937	-0.109	-1.096
Death Education			
No (Yes=0)	-0.503	-0.079	-1.176
(Constant)	-1.156		-0.495
R-square	0.268		

Of the prediction variables used, religious affiliation, religious self-rating, a belief in an afterlife, and occupation are the only three variables that are significantly related to the fear of death.

Previously we did not know how psychologists, social workers, and clergy fir in relation to fear of death. This study has helped us gain some understanding of how fear of death is related to these various health care professions. It is not too surprising that clergy demonstrate the lowest levels of fear toward death. This can mostly be explained by the clergy's professional ideology. That is, religious variables have been shown to be significantly related to fear of death. The clergy ideology is specifically designed as connection to the beyond. The data seem to confirm that religious variables do indeed serve the purpose of helping individuals deal with the fact of death.

Overall, in reference to differences in ranking of the various health care providers, these data cannot pinpoint a specific reason for different levels of anxiety. Possibilities of self-selected occupational recruitment, or socialization processes are not documented by this study. In light of the fact, these data can only serve as a reference point for other researchers to look at.

It is worth noting the differences in the fear of death scales. The metaphor and semantic differential scales produced different results. This seems to imply that they are measuring different death conceptions. By stating this we are suggesting that fear of death is not a unitary conception or homogenous entity, but could be composed of different pieces. This is a concept that is offered by Feifel and Schag (1980). These authors have attempted to appraise fear of death utilizing a variety of measures to capture different levels of awareness such as "conscious level," "fantasy level," and "below-the-level-of-awareness level." Future research needs to take this fact into consideration.

Because of the fallibility of empirical research, one can never perfectly measure health care provider's attitudes toward death. One pressing problem of death attitude research is the imprecise measurement of our indicators. While reliability is a problem confronting all research, it is especially relevant for death attitude studies. Some death attitude research tends to focus on the relative influence of predictors and the patterns of relationships, while expressing less concern for the absolute amount of explained variance. For death attitude research the absolute amount of explained variance is of primary interest. We must address the issue of imprecise measurement of death attitude indicators. We must establish that our measurements are to be valued as descriptions and predictions of human encounters.

Scales currently utilized measure components such as death concern (Dickstein, 1972), death threat (Krieger, Epting, and Leitner, 1974) acceptance of death (Ray and Najiman, 1974), and multiple reactions to death ranging from fears about death or dying of self and others (Collett and Lester, 1969) to denial or avoidance of death and reluctance to interact with the dying (Nelson and Nelson, 1975).

Durlak and Kass (1981) compared these popular scales along with some ten others. In summary, the results of their factor analysis suggest that, on the

one hand, several presumably unidimensional scales are multidimensional in nature, whereas, the names of the many instruments inaccurately identify the constructs being assessed. In conclusion, they state that unless future researchers carefully attend to the construct(s) measured by the scales they employ, the future results of death research is bound to be continually confusing and misleading.

We agree with their statement. Fear of death is too complex a characteristic to be fully understood by the measures utilized in this study. Clearly, then, separating the unreliability of measurement from actual health care provider's attitudes toward death will result in a more accurate assessment. Thus, our current research efforts are being devoted toward developing a scale utilizing the principal component technique in factor analysis. We feel future research efforts should be directed toward the development of more reliable scales due to the only consistent results have been death research reviews which emphasize the methodological limitations in the measurement of relevant constructs (Durlak and Kass, 1981; Kalish, 1985; Katenbaum and Costa, 1977).

NOTES

[1] Some clinicians and investigators hold that most human behavior is a response to the problem of death (Becker, 1973; Feifel, 1971, 1977). Others have asserted that fear of or anxiety concerning death is a universal reaction and that no one is free from it (Caprio, 1950; Rheingold, 1967). Some express the hypothesis that every fear we have is ultimately a fear of death (Feifel and Nagy, 1981).

[2] Of some two million people who die each year, one and one half million will be in the age group over 65. Suffering from chronic illnesses, most of them will die in a hospital or nursing home (Milner, 1980). Since most deaths in the U.S. occur in a hospital or nursing home, health care providers, and health care teams, are in a strategic position to relate to dying patients. The term health care "team" in this study will refer to an interdisciplinary team approach. Conley (1973) has written that only through cooperation and collaboration with other professionals in an interdisciplinary approach are we able to make available quality health services. Team members to be examined in this study consist of physicians, nurses, psychologists, social workers, and clergy. Additionally, in 1947 the World Health Organization defined health a "a state of complete physical , mental, and social well being, and not merely the absence of a disease or infirmity." This definition of health proposed by the World Health Organization broadens the scope of health care from disease and the physical dimension to encompass the multiple dimensions of an individual. The term health care in this study will be consistent with the definition provided by the World Health Organization.

[3] Freud (1914) often wrote on the problems of facing and dealing with death. The subject was a consistent ingredient of how own self-analysis. He poetically treated it in "The Theme of the Three Caskets" (XII, 1913, pp. 289-301), his paper "on Transience" (SIV, 1915, pp. 303-307), and "Mourning and Malancholia" (XIV, 1917, pp. 237-258) as well as many other writings (cf. Moss, McGaghie, and Rubenstein, 1976).

[4] A wide range of published works suggest concern for the dying patient (Diggory and Rothman, 1961; Feigenberg, 1975; Geizhals, 1975; Koenig, 1974; Milner, 1980; and Wahl, 1969).

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